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KANSAS HEALTH POLICY AUTHORITY

December 8, 2010
Kansas Health Policy Authority Oversight Committee
Follow Up from November 4-5, 2010

**What is the timeline for all pharmacy changes?**
See Attached chart.

**Senate Substitute for HB 2631 instructed KHPA to reduce the number of brand name drugs allowed from five to four, what might we save from reducing that limit to two?**

The FY2011 budget included $12 million (all funds) savings associated with reducing the brand limit and implementing a tiered co-pay; the savings projected in the legislative budget bill was based on an increase in the generic dispensing rate (i.e. how often a generic medication is dispensed vs. a brand-name), rather than directly as a result of the policy changes themselves. KHPA is hesitant to project additional short-run savings (FY 2012-2013) that might result from a further reduction of brand name drugs allowed from four down to two.
It is our understanding that the savings proposed by the legislature was estimated by what could be saved if the generic dispensing rate for Kansas Medicaid was as high as that of neighboring Oklahoma Medicaid – 4.4% higher. Kansas and Oklahoma have a different set of pharmacy policies that contribute to the overall rate of generic dispensing. The brand limit utilized by Oklahoma Medicaid is two per calendar month, with only cancer, HIV, and oral contraceptives exempted. Since this year's budget already assumes Kansas will reach Oklahoma's generic dispensing rate, reducing the number of brand name prescriptions allowed in Kansas to the number allowed in Oklahoma is not anticipated to result in a *higher* generic dispensing rate than that experienced by Oklahoma.

In addition to a two brand limit, Oklahoma utilizes a tiered formulary system. Counter-intuitively, implementation of a tiered formulary in Kansas would result in a short-term increase in Medicaid expenditures. This is caused by a difference in federal co-pay requirements between tiered and non-tiered programs. For all providers, any patient co-pay amount is subtracted from the payment to the provider. For example, a $10.00 pharmacy claim with a $3.00 co-pay amount results in a $7.00 Medicaid payment to the pharmacy. Under federal requirements *for tiered formularies*, a $10.00 pharmacy claim is allowed a co-pay of no more than $0.60. The Medicaid payment to the pharmacy for a $10.00 claim in a tiered formulary is therefore $9.40, an increase of $2.40 over the payment in our current system. Over 70% of pharmacy claims would result in a higher cost-sharing requirement for Medicaid. We estimate this would result in an expenditure increase of $1M in the first fiscal year. The increase in expenditures could likely be recouped from the migration to lower-cost products cause by tiered formularies by inducing more prescriptions for $10 dollar generic drugs and fewer $50 dollar brand name drugs, but not within one fiscal year as this requires a change in physician prescribing patterns.

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**Do we send an explanation of benefits to Medicaid recipients and are notification for payment of services to consumers provided?**

The Single State Medicaid Agency is required to have a method for verifying with recipients whether services billed by providers were received (42 CFR §455.20(a)).
KHPA currently sends Explanations Of Medical Benefits (EOMB) to 400 randomly selected fee-for-service recipients each month. In an informal survey of states conducted in January of 2009 through the National Association for Medicaid Program Integrity list serve, 14 of the states responded to the questions related to methodology used to issue EOMBs. Their responses indicated that they also were sending EOMBs to a sample of their recipient population.

**Is there a way to measure the advantage providing consumers with notification that a service have been paid for on their behalf?**

KHPA tracks the number of responses received as a result of the letters and any needed corrective action. In 2009, we received inquiries on 2.7% of the letters sent and 1.6% of the claims were questioned. From January through October 2010, we received inquiries on 1.4% of the letters sent and .07 % of the claims were questioned.
Further investigation of the questioned claims did not result in any finding.

**What percentage of beneficiary's charts are reviewed for appropriate use?**

KHPA conducts monthly chart evaluation as part of its utilization review processes.

1- *Surveillance and Utilization Review Subsystem (SURS)* - Federally mandated to monitor providers and consumer of Medicaid services:
SURS performs post-payment provider review, consumer reviews and data analysis to safeguard against unnecessary or inappropriate use of services and against excess payments, assess the quality of services and provide for control of the utilization of all services provided. In fiscal year 2010, HP completed 140 reviews. An estimated 14,700 charts were reviewed.
2- *Hospital Utilization Reviews* -–KHPA contracts with Kansas Foundation for Medical Care (KFMC)
KFMC conducts reviews of a sample of fee for service inpatient hospital and ambulatory surgery center claims. Each claim requires a chart review. In fiscal year 2010, KFMC reviewed 14,173 charts.

**Why did we go with PSI over Maximus**?
See Attached, May 20, 2009 letter.

**How many staff does PSI have?**
PSI currently has 152 employees.

**Provide flow chart for how an application is received.**
See Attached Flow Chart.

**Was Maximus penalized for the backlog?**

No liquidated damages were assessed against MAXIMUS because they were not in default under their contract.

The scope of the contract significantly changed since 2003; the number of applications and reviews received by the Clearinghouse doubled and in July 2006, the citizenship and identiy verification requirements were implemented. While the contractor requested and received some additional resources to compensate for the additional workload, some of their requests were denied for lack of funding and when funding increases were authorized by the State, they were never sufficient enough to keep pace with the cost associated with the additional amount of work. Therefore compromises had to be reached regarding performance.

**PSI Contract amounts:**

| | |
|---|---|
| 1st Year Contract Price (FY10) | $7,194,228 |
| Amendment 1 reduction (FY10) | ($884,735) |
| Total Price for FY10 | $6,309,493.00 |
| | |
| 2nd Year Contract Price (FY11) | $9,720,282 |
| Amendment 2 reduction (FY11) | ($1,062,310) |
| Total Price for FY11 | $8,657,972.00 |
| | |
| 3rd Year Contract Price (FY12) | $9,883,720.00 |
| 4th Year Contract Price (FY13) | $10,049,880.00 |
| 5th Year Contract Price (FY14) | $10,130,879.00 |
| 6th Year Contract Price (FY15) | $9,840,755.00 |

**How many appeals has KHPA lost due to the increased time to process HealthWave applications?**

There has only been one HealthWave application processing case that has gone to appeal. It is currently in litigation. KHPA has tried to work with families whose applications have taken longer than 45 days to offset any costs they may have incurred during their wait.